MONTANA CHEMICAL DEPENDENCY CENTER
POLICY AND PROCEDURE MANUAL

Policy Subject: Clinical Record Keeping	Related Policies:
Policy Number: CPT 26	Standards/Statutes:Federal Register, Volume 40, NO. 127, Part IV, July 1, 1975.
Effective Date: 01/01/02	Page 1 of 5

PURPOSE: To standardize patient records to ensure that accurate, appropriate information is maintained, is readily accessible, and that the record meets state and national accreditation standards.

POLICY: Clinical records will be maintained for each patient in compliance with state and federal standards.

PROCEDURE:

I. The team the patient is assigned to is responsible to keep the patient's record current, in proper order, it will be legible by utilizing computer documentation and saved in approved clinical software format.

II. Patient files will be kept in a secure manner at all times.

III. Confidentiality of patient records will be maintained in accordance with federal confidentiality rules and regulations.

IV. Progress notes will be completed a minimum four times per week describing the patient's behavior in such a way as to indicate progress, or lack thereof, toward the treatment plan goals. All collateral contacts will be documented in the patient's file.

V. Each counselor will keep his/her patient's files in the order as delineated on the file management form. All forms will be properly dated, signed, and witnessed.

VI. Progress Notes are to be kept as follows:

A. Within 48 hours of admission to the treatment unit the initial note and treatment plan must be completed.

B. Document a minimum of four times each week. This program uses the Data, Assessment, Plan method of documentation. This documentation will include:

1. A minimum of 1 individual counseling session, 1 group note, one weekly summary and a weekly interdisciplinary clinical staffing note. In addition, any other note worthy event will be documented.

2. Clear descriptions of patient's progress.

3. Correlates to the treatment plan with completion dates on the treatment plan.

4. Identifies the type of session, i.e., 1:1, and group.

5. Clinical meetings.

6. Case management contacts must also be documented in the patient file, i.e. telephone contacts with outside sources, family, agencies, legal system, etc.

7. All specialty group attendance.

VII. Referral information, court orders, and all outside data information will retained in the patient record.

VIII. Discharge Summaries and all accompanying documentation must be submitted to the Medical Records Department within 48 hours of normal working hours after discharge.

IX. Continued stay for level III care is an ongoing evaluation of the treatment planning process. Each patient's case will be reviewed for appropriateness for continued stay at the medically Monitored Inpatient level of care.

A. In conjunction with the treatment process, at approximately 10-18 days, a continued stay review will be done to assure quality of treatment planning and appropriate level of care. A team approach under the supervision of the Clinical Supervisor will be utilized with the patient in attendance. The counselor utilizing the Continued Stay Review Form, which will be signed by the patient and the team members present and retained in the patient's file, will complete the record of the clinical stay review.

B. Continued stay criteria to be considered in assessing appropriateness of placement will be:
   1. Continued withdrawal symptoms including evidence of post withdrawal (e.g., memory problems, poor cognitive functioning)

   2. Continued biomedical problems.

   3. Progress toward resolution of an emotional/behavioral issues.

4. Progress toward understanding of alcohol/drug problem with the reduction in treatment resistance.

5. Level of understanding of relapse triggers.

6. Level of resolution of problems within the recovery environment.

7. The evaluation of progress towards the patient's individual treatment goals will be assessed by the stage of change and the learning phase the patient has achieved related to each dimension.

C. Current clinical problems will be identified and documented. The treatment team will then recommend updated problems for the treatment plan.

D. Treatment plans will then be updated to include the identified problems, goals, objectives, and treatment strategies to accomplish goals.

E. Any patients can be staffed whenever necessary, and will include a multiple-disciplinary team approach for problem resolution, and establishment of new goals and objectives.

F. If the continued stay review indicates that the patient is no longer appropriate for level III care, the patient will be referred to the level of care better suited to their needs.

1. At least twice during the treatment process, at approximately 10 -14 days, and again approximately 25-30 days a continued stay review will be done to assess quality of treatment planning and case management and assess continued stay. A team approach under the supervision of the Clinical Supervisor will be utilized.

2. The counselor, utilizing the Clinical Stay Review Form, to be retained in the patient's file, will complete a record of the clinical stay review.

3. Reduction of symptoms in each of the clinical dimension will be noted and current clinical problems will be identified and documented. The treatment team will then recommended updated problems for the treatment plan. If the continued stay review indicates that the patient is no longer appropriate for level III.7 care, the patient will be referred to the level of care better suited to his/her needs.

X. Treatment plans will then be updated to include the identified problems, goals, objectives, and treatment strategies to accomplish goals.

XI. Any patient can be staffed, whenever necessary, and will include the interdisciplinary staff necessary for problem resolution.

XII. Every patient completing the program will receive a referral to a community state approved program with a follow up plan addressing specific early recovery issues.

XIII. Mental Health assessments and referrals will be included in the continuing care plan for those patients identified with mental health issues.

XIV. An Individualized Treatment Plan will be developed for every patient within two working days following admission to the primary treatment unit.

A. Within two working days after a patient is assigned to a counselor, the counselor will develop an individualized treatment plan.

B. Each treatment plan will be individualized to the specific patient.

C. Treatment plans will include a description of the identified problems and various therapeutic methods employed in the total treatment program and any support services needed to assist the patient in resolving the identified problems.

D. The treatment plan will include problem statements, goals, objectives, and methods to be accomplished in order to complete the MCDC program. Thus, the treatment plan is a critical tool in the patient's progress.

XV. TREATMENT PLANS MUST BE COMPLETELY FILLED OUT.

A. The counselor in consultation with the patient will define problems, objectives, and methods in terms that are specific and obtainable within the time frame of treatment.

B. The procedures for individualized treatment planning are:

1. Problem/Symptom - the counselor will enter a statement of the specific problems/symptom, which have been identified as a treatment priority with the patient. The statement must be sufficiently concrete to allow definable actions, which will halt the problem/symptom.

2. Treatment Goals - the counselor and, and the patient will agree upon specific goals which, if accomplished, would counter the problem/symptom as stated. These goals must be stated precisely enough that it can be determined whether the patient has accomplished the goals by evaluating the stages of change and learning phase the patient is in related to problem reduction.

3. Treatment Objectives - Objectives include time limited behavioral changes or action expected of the patient. A targeted date for completion will be

included.

4. Treatment Methods - This column includes specific tasks set to accomplish the treatment goals and objectives. These tasks are very specific, easily measured, and itemized in such a way that they can be checked off one at a time. Each task must relate directly to the goal to be accomplished and, in turn, to the problem/symptom being addressed.

5. Completion Dates - The counselor will enter in this column the dates the patient completes each task listed under treatment methods.

XVI. Within each seven- (7) day period after the patient's arrival on the primary treatment unit, the counselor will review the individualized treatment plan with the patient and record the date of each interview.

XVII. The patient and the counselor will sign and date the treatment plan. In most cases, it is appropriate for the patient to have a copy of their treatment plan.

XVIII. Treatment plans are considered a working instrument and must be constantly altered and updated as treatment progresses. Changes, additions, and deletions in the treatment plan must be substantiated by appropriate annotations in the progress notes.

Revisions: 6/23/03

Prepared By: Steve King Chemical Dependency Supervisor 6/23/03
Name Title Date

Approved By: 06/30/03
David J. Peshek, Administrator Date